

HOSPICE SERVICES PAYMENT SYSTEM

payment**basics**

Revised:
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The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show continued acceleration in use of the hospice benefit among Medicare beneficiaries and associated program spending. The rate of hospice use grew from 22 percent of decedents in 2000 to 31 percent of decedents in 2004. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program rose 26 percent from 2001 to 2005. In addition, as of February 2006, 46 percent of hospice agencies were for profit, compared to 31 percent in 2001. Medicare payment for hospice grew from \$2.9 billion in 2000 to \$6.7 billion in 2004. Hospice services' spending is projected to increase at an average annual rate of 9 percent per year from 2004 to 2015.

The hospice product and Medicare payment

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type of care, the benefit covers an array of services, such as:

- skilled nursing services,
- drugs and biologicals for pain control and symptom management,
- physical, occupational, and speech therapy,
- counseling (dietary, spiritual, family bereavement, and other counseling services),
- home health aide and homemaker services,
- short-term inpatient care,
- inpatient respite care, and
- other services necessary for the palliation and management of the terminal illness.

Setting the payment rates

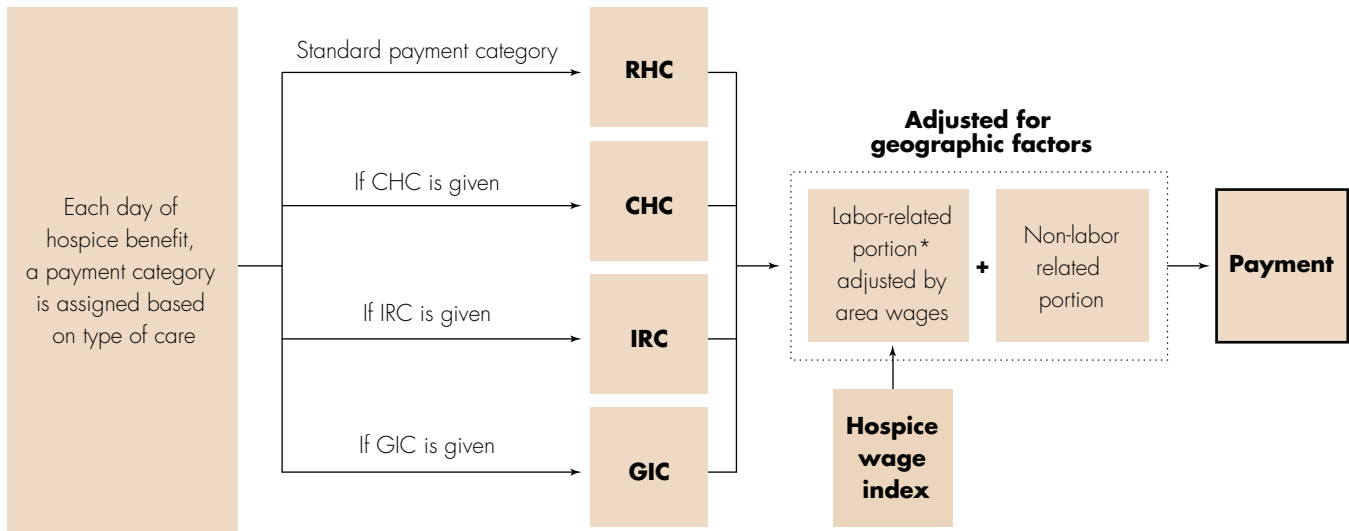
Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and even on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four base payment amounts for the four different categories of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1). The four categories are distinguished by the location and intensity of the services provided and the base payments for each category reflect variation in expected input cost differences. Unless a hospice provides CHC, IRC, or GIC on any given day it is paid at the RHC rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change. Ninety-three percent of days of hospice care provided are at the routine home care level.

*This document does not
reflect proposed legislation
or regulatory actions.*

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Figure 1 Hospice prospective payment system



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care).

*The labor-related portion adjusted by the wage index varies, depending on payment category (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each category of care's base rate has a labor share and a nonlabor share; those amounts differ across each category. The labor share of the base payment amount is adjusted by the hospice wage index for the location in which care is furnished and the result is

added to the nonlabor portion. The base rates are updated annually based on the hospital market basket index.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20

Table 1 Hospice payment categories and rates

Category of care	Description	Base payment rate, FY 2007	Labor-related portion of payment adjusted by the wage index, FY 2007
RHC	Home care provided on a typical day	\$131	69%
CHC	Home care provided during periods of patient crisis	763	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	135	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	582	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate (\$763.36=24 hours of care at \$31.81 per hour) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment.

Source: CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1023, "Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2007." August 4, 2006. Accessed on August 21, 2006.

percent of its total patient care days. The other cap is an absolute dollar amount, based on the number of Medicare patients the agency serves. Total payments over total number of beneficiaries may not exceed \$20,585 in the year ending October 31, 2006. Unlike the daily rates, the caps are not adjusted for geographic differences in costs. The hospice caps are adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Hospice payments were calculated based on information from a Medicare demonstration project completed in the

early 1980s. The program has not examined the set of services included in the payment since then to reflect changes in patterns of hospice care and associated costs.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was \$952 in 2006. ■